UTAH COALITION FOR
OPIOID OVERDOSE PREVENTION

Round Table Discussion Guide
May 4, 2018

OBJECTIVES:

- Start the conversation between providers and payers on how to best work together to solve the opioid abuse problem in Utah
- Collaborate to improve pain management and mental health services throughout Utah
- Define prevention strategies and treatment of opioid abuse from both the payers' and providers' perspectives
- Devise collaborative next steps/action plan

Section 1 - General Questions **(should be answered by both insurers and providers):**

Providers, insurers, and policy makers all have a responsibility in this public health crisis that we refer to as the opioid crisis. We hope by starting a dialogue together, we can come to some common ground on this important issue. We believe that in order for providers to facilitate efficient and effective pain management care, access to mental health and complementary therapy options is necessary to help reduce the opioid burden. We have a unique opportunity to make a difference. If we unite in our efforts, we can help manage/end this crisis.

Questions for consideration:

In five minutes or less, please provide a summary of your insurance company's action plan to address the opioid epidemic. (One representative per insurance company)

1. **Do you see a need to collaborate with the health care community outside of your insurance system in finding solutions for this crisis?**
2. **Do you believe there is a need to modify payment systems to allow for better chronic pain care and reduce the use of opioids?**
3. **As a payor, do you set your own reimbursement rates or does another entity set them? If another entity sets them, do you have leverage to change them if you disagree with them? In other words, what role do PBM's play in reimbursement rates?**

Section 2- Opioid addiction prevention

Recent studies show that more than half the prescriptions for painkillers went to individuals with depression and anxiety. In addition, adults with mental health disorders are much more likely than people without them to use prescription opioids — 18.7 percent vs. 5 percent - yet it has been estimated that 90% of doctors do not screen for mental health issues before prescribing opioids. (Dartmouth-Hitchcock Medical Center & University of Michigan study, 2017). In addition, studies show that when mental health issues in pain patients are treated first, whether with medications or therapy, pain is reduced. The Centers for Disease Control and Prevention

(CDC), the American Pain Society and others have recommended conducting psychological assessments before prescribing opioids, yet many insurances do not cover this screening.

As medical practitioners, we believe a good public health approach is to identify patients at risk for opioid misuse or a substance use disorder. We recommend this because opioids are rarely the only drug being misused. Knowing if one's patient is at risk for addiction allows the health care provider to make better choices when treating pain. We believe that addiction prevention should be a priority for many medical practitioners. Screening and discussing substance use, including opioid misuse, has shown to be cost-effective within the health care and criminal justice system. Coordination of services can greatly benefit this endeavor. (Estee, S., He, L., Mancuso, D., Felver, B. (2006). Medicaid Cost Outcomes. Department of Social and Health Services, Research and Data Analysis Division: Olympia, Washington.)

Questions for consideration:

4. **What is your policy with regard to mental health and pain management? Do you cover CBT, meditation or other mental health modalities when related to pain management?**
5. **Are you familiar with HB 175 that provides reimbursement to Medicaid doctors for SBIRT or psychological assessment codes before prescribing opioids? Do you encourage your practitioners to do SBIRT? Does your insurance reimburse doctors for SBIRT or psychological assessment? If not, what is your rationale for not reimbursing?**
6. **Aside from SBIRT, do you have other evidence-based screening/intervention suggestions that could be utilized to help providers understand their patient's risk level?**

Provider Recommendations: Provide incentives that encourage practitioners to assess for Mental Health issues prior to prescribing opioids. Reimburse for SBIRT codes.

Section 3 - Pain Management (Acute and Chronic)

Opioid misuse, abuse and addiction is a public health crisis that has been labeled as the "opioid epidemic". Although this is true, we need to recognize that this stems from a chronic pain epidemic/crisis. More people in the United States are suffering from chronic pain than diabetes, cancer, and heart disease combined (NCHS, Health,2006 with Chartbook on trends in the health of Americans. Hyattsville, MD: US Department of Health and Human Services: 2006). This number is only growing and chronic pain is not going away. Providers and insurers need to address an improved and more efficient management of chronic pain patients.

When asked how they could reduce their opioid prescriptions, Utah doctors clearly stated that they simply needed options/alternatives. They believe that alternative options need to be tried or at least considered prior to prescribing opioids. Options that are evidence-based and not cost prohibitive are most desirable. These approaches could include, but are not limited to, the following, starting with least invasive: 1. Cognitive behavioral approaches 2. Rehabilitative approaches 3. Interventional approaches 4. Pharmacological approaches. Many doctors were either unaware of the alternatives, the alternatives were cost prohibitive, non-covered, or there

were other obstacles preventing them from prescribing the effective alternatives to opioids. In order for providers to manage chronic pain they must have the appropriate and full complement of tools in their toolbox.

Questions for consideration:

7. **Do you see barriers to insurance coverage and provider referral for these and other alternative therapies for pain management?**
8. **We as physicians have experienced a number of evidence-based treatments for pain management that are not approved for insurance coverage. This limits how we can treat and often pushes patients towards opioid treatments. How can this problem be addressed in ways that lead to solutions?**
9. **We must not forget the patient in this opioid crisis. They must remain front and center. For many payers, one of the answers to the opioid problem is to encourage the provider to reduce the number of pills in a prescription or to reduce the number of prescriptions all together. This has caused an outcry among patients, especially those who are low risk for abuse and have been on a certain regimen for years effectively. They feel they are being unfairly targeted. What are your thoughts on this?**
10. **We know from the research that when the number of opioid prescriptions go down, heroin use goes up. How can we effectively find solutions so that heroin abuse does not spiral out of control in patients with chronic uncontrolled pain?**
11. **Customer satisfaction forms have become a problem for providers especially with regard to the opioid abuse problem. If patients are not given viable options to help manage their pain, besides opioid, this could be interpreted by the patient that the provider is not listening, does not believe that they are in pain, or is not empathetic. This will typically result in a negative review. What do you see as the solution for this?**

<u>Policies that may be deterring effective care</u>

There are policies in place that seem to deter effective care. Some examples include:

- Some beneficial treatments, such as regional anesthesia, are reimbursed at rates that don't justify the effort made by providers
- Procedure options are sometimes limited by a patient's insurance plan.
- Some treatments require multiple co-pays for a single treatment plan such as with spinal manipulation, physical and psychological therapies

Provider Recommendation: Limited or decreased co-pay for multiple visit treatment plans such as with Chiropractic, PT, or Psychological therapies.

- High deductible plans incentivize patients to delay needed care until it becomes an emergency or a chronic issue
- Some treatments require authorization that may take days or even months, causing them to rely on opioids until such time as treatment is approved

Provider Recommendation: Eliminate pre-authorizations for treatments that are recommended in approved guidelines (CDC, or others)

- As medical providers, we experience a shortage of credentialed behavioral health providers for referral purposes who can specifically work with addiction and pain management patients, yet the processes to be added to an insurance panel is extremely difficult
- Sometimes providers are credentialed in one location in Utah, but not in another location in Utah. Particularly in the area of pain management and addiction, could this be revised?
- Costs are reduced when treatment is handled at the lowest level possible. Some treatment options can be implemented at lower levels, but are denied payment when performed by certain provider groups.
- Opioid use could be better monitored with more frequent refills, but some insurers require another copay when providers use the "fill half" concept for opioids
- Some medications are incentivized based on cost rather than outcome. Insurance companies typically have a set pharmacy formulary for prescribing medications. Formulary restrictions can require a provider to prescribe a schedule 2 medication before a schedule 3 medication. For example, prior to using a medication such as Belbuca a patient will need to try and fail schedule 2 options such as hydrocodone, oxycodone, Morphine ER etc.
- Inpatient situations require supervision even when implementing the primary recommended treatments such as exercise. Beginning these in that setting would be beneficial, but lack of reimbursement limits implementation.

Provider Recommendations:

- Provide incentives for providers to utilize current guidelines for pain management.
- Add more providers to your behavioral health network.
- Encourage certification in pain management put out by UMA, UCPA, Insurance Companies. That gives insurers a way to create preferred provider incentives, also sets a standard by which providers can be measured. Builds public awareness and unites groups across the state in a proactive action.
- These barriers to effective opiate-sparing tools deter patients from receiving alternative treatments and promote the easier route of prescribing opioids.

12. How can we improve access to and reimbursement of alternative treatments so that we are not deterring effective care?

Other Provider Recommendations:

- Insurance brackets which offer chronic pain coverage that allow for discounted access to certain treatments at a higher premium.
- Recent findings published in the Lancet indicate:
    - We are not following the research, we need to actually implement best practices and guidelines
    - We need to redesign some clinical pathways to allow clinicians to follow the evidence

- Integrated health care needs to become the norm
- To allow this to happen changes to payment systems and legislation need to happen
- Public health and prevention strategies of exercise and education need to be implemented

13. What do you see as priorities to begin working on?

Section 4 - Substance Use Disorder Treatment

Some conditions require multiple attempts at treatment or long-term care. For example, patients may require rehabilitation programs multiple times. Chronic pain may be managed by physical modalities rather than opioids but may require significantly more visits than most insurances allow.

14. Does your insurance company cover rehabilitation programs or chronic pain management, and recognize through coverage that the patient may need this service more than may be currently covered?

15. Does your insurance company help to educate patients about best practices with MAT if they have an opioid use disorder? What is your policy regarding coverage of suboxone vs. vivitrol?

16. Are the payers promoting short rehabilitation treatment center stays over longer, less intensive treatment? What is your insurance company's rationale for utilizing one over the other? Does your company provide adequate information to assist the patient with making an informed decision if the patient is part of the decision-making process?

17. Do more guidelines need to be in place and outcome studies be required of treatment centers? How do insurances decide what recovery centers they will reimburse for treatment?